THE UNIVERSITY OF THE WEST INDIES
CAVE HILL CAMPUS

Faculty of Medical Sciences
Remote Teaching Form

NAME:

STUDENT IDENTIFICATION NO:

OVERSEAS ADDRESS:

TEL NO: Home: **Cell:**

EMAIL ADDRESS:

REASON FOR REQUESTING REMOTE TEACHING

TYPE OF INTERNET CONNECTION AND CONNECT AND BANDWITH

TYPE OF ELECTRONIC DEVICE YOU INTEND TO USE FOR REMOTE LEARNING:

(Provide details on the operating system of the device and if you have a functional web camera and microphone that can be used with the device)

By signing below, I certify that the information provided on this form is factual.

Signature **Date**

For Faculty of Medical Sciences use only

APPROVED (Dean, FMS) _____ **Date** _____

NOT APPROVED (Dean, FMS) _____ **Date** _____